Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		COMPLETED							
HAL054062		B. WING		R 06/08/2016								
HALU54062					1 06/06/2016							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
KINSTON ASSISTED LIVING 2130 ROSE VISTA ROAD KINSTON, NC 28504												
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE							
{C 000}	Initial Comments		{C 000}									
	This report is of a F Getchell on June 8,	ollow Up Survey done by Bob 2016.										
		y revealed that all deficiencies ected, therefore a new plan of ed.										
{C 164}	Housekeeping and Furnishings-Clean, Repaired		{C 164}									
	SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; (2) have no chronic unpleasant odors; (3) have furniture clean and in good repair; (e) This Rule shall apply to new and existing facilities.											
		vation, the facility failed to , and floors or floor coverings,										
		on June 8, 2016: stained, and dirty at the o include but not limited to:										
	d. The carpet at the worn away.	door to Bedroom 102 was										
		d review revealed the facility to the for the carpet replacement of June 27, 2016.										
{C 189}	Building Equipment	Maintained Safe, Operating	{C 189}									

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED				
		HAL054062	B. WING			R 08/2016				
NAME OF PROVIDER OR SUPPLIER KINSTON ASSISTED LIVING STREET ADDRESS, CITY, STATE, ZIP CODE 2130 ROSE VISTA ROAD KINSTON, NC 28504										
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	(X5) COMPLETE DATE					
{C 189}	SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (a) The building an mechanical, and plucare home shall be operating condition (k) This Rule shall facilities with the exwhich shall not app This Rule is not med. Based on Observating and the shall not app This Rule is not med. Based on Observating in a safe because some build function as originall. Followup Findings of a. In the TV Room more than normal edoor had a split in it the floor. b. The bottom of the and cannot be easily interview and recording the same control of the same cannot be easily interview and recording the same cannot be easily interview.	PHYSICAL PLANT 11 OTHER d all fire safety, electrical, umbing equipment in an adult maintained in a safe and apply to new and existing ception of Paragraph (e) ly to existing facilities. et as evidenced by: vation, the Building was not e and operating condition, ding components fail to y intended. on June 8, 2016: the corridor door, requires effect to open because the is jamb allow the door the hit	{C 189}							

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